MEDICARE SET-ASIDE RECONSIDERATION AND AMENDED REVIEW

OPTIONS FOR OVERCOMING AN UNEXPECTED MSA DETERMINATION OUTCOME

47th Annual Kansas Workers Compensation Seminar
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September 29, 2021

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- MSA submission is a voluntary, yet recommended, process which offers both Medicare beneficiaries and WC entities finality with respect to obligations for medical care post settlement (*WCMSA Reference Guide V. 3.3, 4/19/2021)*
- There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review.
- MSA submission = *agreement to comply with CMS' established policies and procedures*.

Timing is Everything- When to Submit the Medicare Set Aside

- Medical portion of claim is being resolved
- Claimant is a Medicare beneficiary and settlement is greater than $25,000
- Claimant has reasonable expectation of becoming a Medicare beneficiary within 30 months of claim settlement AND settlement is greater than $250,000

If the settlement does not meet the current workload review thresholds, CMS will not issue a "verification letter" indicating that the review criteria have not been met, or indicating that a WCMSA is unnecessary.

What Do You Do When…

Medical Expenses Over LE:	$40,676.00
Pharmacy Expenses Over LE:	$2,000.00
Total Medicare Covered Expenses Over LE:	$42,676.00

And this happens…

Dear Sir or Madam,

This letter is in response to your submission of a proposed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amount related to the above-named claimant's workers' compensation claim and received on 10/12/2020.

You proposed a WCMSA amount of $42,676.00 to pay for future medical items and services that are covered and otherwise reimbursable by Medicare ("Medicare covered") and are related to the above-named claimant's workers' compensation claim.

We have evaluated your proposed WCMSA amount and have determined that $240,734.00 adequately considers Medicare's interests with respect to Medicare-covered future medical items and services, including prescription drugs.

You've got Options

Re-review or reconsideration of the CMS determination is a processes put into place to allow submitters and claimant's to address their dissatisfaction with WCMSA determination.

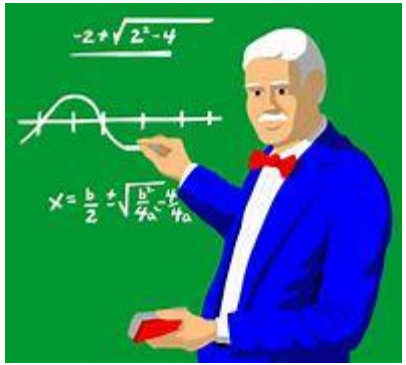
There are 3 types of reconsideration requests that CMS may permit. A submitter may request review due to:

1. **Mathematical error**
2. **Missing Documentation (or documentation not available at the time of submission)**
3. **Amended Review**

Mathematical Error Review

Mathematical Error (WCMSA Reference Guide Section 16.1)

Where the appropriately authorized submitter or claimant disagrees with WCMSA decision because the determination contains obvious mistakes (e.g., a mathematical error or failure to recognize medical records already submitted showing a surgery, priced by CMS, that has already occurred)



When It's Not a Mathematical Error

CMS determination letter says:

We have evaluated your proposed WCMSA amount and have determined that $33,865.00 adequately considers Medicare's interests with respect to Medicare-covered future medical items and services, including prescription drugs.

And the CMS letter also says this

The following chart summarizes the services and costs that adequately protect Medicare's interests:

Subtotal Future Treatment: $19,964.00
Subtotal Prescription Drugs: $15,282.00
Grand Total: $35,246.00

CMS 5% Rule (WCMSA Reference Guide Section 9.4.4 Step 10)

- If the recommended WCMSA amount (which is a combined total of medical and prescription costs) is within 5% of the submitter's total proposed WCMSA amount, the WCRC recommendation is approval of the **submitter's proposed amount**.
- In structured cases, the seed amount is separately calculated. If the recommended initial deposit is within 5% of the submitter's initial deposit, the WCRC recommendation is approval of the submitter's proposed seed amount.

Missing Documentation Review

Missing Documentation Review

- Where the submitter or claimant disagree with WCMSA determination on the grounds that there exists additional evidence not previously considered by CMS, a re-review request can be made.
- The additional evidence must be dated **prior** to the date of submission and demonstrate that a change in WCMSA determination is warranted.
- CMS will not consider documentation obtained and dated after the date of the CMS determination letter.

Missing Documentation Review

Case Study I:

The medical record demonstrated that claimant was taking Meloxicam 7.5mg at the time that the MSA was completed. The MSA was submitted to CMS shortly after completion. While the MSA was being reviewed by CMS it was discovered that claimant began taking Meloxicam 15mg. The CMS determination contained a pharmacy allocation including 7.5mg of Meloxicam. The submitter obtained a treatment note and pharmacy log showing that the claimant's medication was changed to 15mg of Meloxicam prior to the submission date and CMS determination letter. The submitter requests that CMS review the information and revise the MSA allocation.

Outcome: CMS agrees and issues a new determination letter removing the Meloxicam 7.5mg and including 15mg of Meloxicam.

Missing Documentation Review

Case Study II:

The medical record demonstrates that claimant is being prescribed Medication A. Medication A is available in both brand and generic formulations. The MSA proposal is written to include an allocation for the generic formulation of Medication. The MSA is submitted to CMS for review. CMS issues a determination that includes the brand formulation of Medication A. This has caused the MSA to increase by $20,000. Andy Attorney contacts the treating MD and she agrees that claimant can take generic Medication A. Andy Attorney has the treating MD provide a letter indicating the same. Andy Attorney submits this letter to CMS and request that CMS remove brand medication A and include the generic medication instead.

Outcome: CMS says NO!!! The information submitted for review was dated after the date of the CMS determination and does not demonstrate that a change is warranted.

Amended MSA Review

Amended Review

- Amended Review process is first formal review process established by CMS for review of WCMSA determination.
- The concept of Amended Review was first introduced by CMS in version 2.6 of the WCMSA Reference Guide released in July 2017.
- The Amended Review timeframe was initially 4 years and in 2019 the timeframe was extended to 6 years for the date of the CMS determination.
- Amended Review is an opportunity to ask CMS to review and revise the previously issued MSA determination.

Amended Review Criteria

1. The case has not settled as of the date of the request;
2. It has been at least **1 year** but not more than **6 years** since CMS issued the determination letter.
3. There is a change in the MSA of at least 10% or $10,000 since the CMS determination letter was issued.
4. No previous Amended Review request. CMS only permits a **one-time** request.
5. Amended Review request does not have to be submitted by the original MSA submitter.

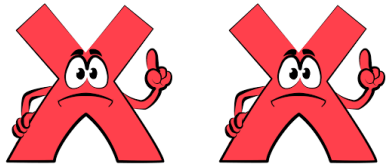
* CMS will not review an Amended Review request where the change in treatment is based solely on a medication change from ***brand* to *generic***.

What Information Is Needed For an Amended Review Request

The Submitter must provide:

1) The rationale for the amended review request;
2) All medical documentation related to the settling injury(s)/body part(s) since the date of CMS determination;
3) The most recent six months of pharmacy records;
4) A consent to release signed and initialed by the claimant;
5) A summary of expected future care (a new MSA proposal);
6) The CMS Recommendation Sheet that was included with the original determination.

When CMS Will Disallow Amended Review



- Submitter cannot demonstrate projected change of 10% or $10,000 in MSA value;
- Request is based solely on the change of a medication noted in the original determination from *brand to generic;*
- No justification for the request is provided;
- No supporting documentation is provided at the time of the request. All documentation must be submitted at the time that the initial Amended Review request is made. The submitter is not permitted to supplement;
- Request submitted with no signed and initialed claimant consent;
- Request submitted prior to the 1-year or after the 6-year timeframe.

Case Considerations

Thoroughly review the allocation tables in CMS determination letter.

Audit cases for unsettled files where the CMS determination letter was received within a 1-6 year timeframe.

Revisit claims that did not settle because the MSA allocation was too high.

Review claims with:

a. high-cost drivers including Spinal Cord Stimulators
b. Surgeries included in MSA determination
c. High dollar pharmacy (e.g. opioids)
d. High dollar DME

Thank you for attending this presentation.

For questions or more information please contact:

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